Country Monitoring and Accountability System Visit to South Africa – April 8-12, 2013
Summary of Key Findings and Recommendations

Introduction

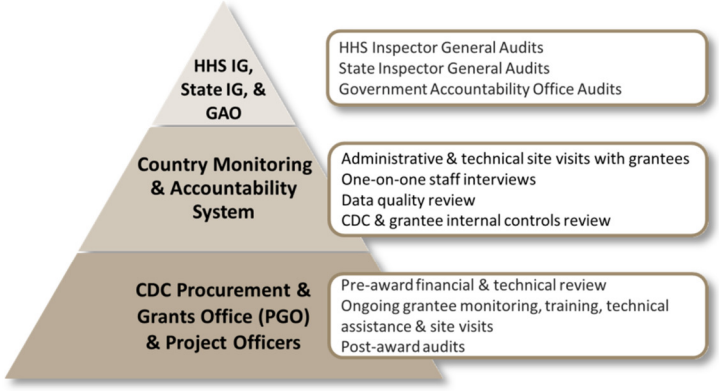
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global AIDS Coordinator (OGAC). CDC uses its technical expertise in public health science and long-standing relationships with Ministries of Health (MOH) across the globe to work side-by-side with countries to build strong national programs and sustainable public health systems that can respond effectively to the global HIV/AIDS epidemic. CDC global HIV/AIDS PEPFAR-related activities are implemented by the Division of Global HIV/AIDS (DGHA) in CDC's Center for Global Health. PEPFAR activities represent the largest portfolio of global health activities at CDC.

CDC's Country Monitoring and Accountability System

CDC/DGHA launched the Country Monitoring and Accountability System (CMAS) in 2011 to identify challenges resulting from the rapid scale-up of complex CDC/PEPFAR programming as a part of CDC's commitment to transparency and accountability. This initiative serves as a basis for ongoing, monitored quality improvement of DGHA's programs and operations through internal programmatic and financial oversight. CMAS is a proactive response on the part of CDC to: 1) ensure accountability for global programs and proper stewardship of U.S. government resources by promoting explicit performance standards and defining expectations for bringing all components of program accountability up to the highest standards; 2) ensure DGHA is supporting DOS, OGAC, and the Presidential Initiatives; 3) serve as a basis for ongoing, monitored quality improvement; and 4) effectively prepare CDC for future oversight audits, congressional inquiries, and special data calls.

CDC Commitment to Accountability

Ensures optimal public health impact and fiscal responsibility



CDC also maintains a Global Management Council chaired by CDC's Chief of Staff which meets regularly to address cross-cutting issues related to the management and oversight of CDC's global programs.

The CMAS strategy was designed to systematically assess CDC's accountability and proper stewardship of U.S. government resources and provide feedback on key business and program operations in the following key areas:

- **Intramural Resources**: Ensuring proper management and stewardship of financial resources, property, and human resources within CDC's overseas offices
- **Extramural Funding**: Ensuring responsible and accurate management of financial and other resources external to CDC's overseas offices
- **Public Health Impact**: Ensuring the delivery of consistently high quality interventions and technical assistance that positively impact the populations the program serves

The first round of CMAS visits (formally known as Country Management and Support visits - CMS I) took place between February 2011 and March 2012 and assessed 35 country offices. A second round of CMAS visits (CMAS II) evaluated 30 country offices and one pilot. A few CMAS II visits were cancelled due to political unrest. CMAS II assessments occurred between June 2012 and June 2014 and increasingly emphasized supportive technical assistance to ensure continual quality improvement. In addition to the focus on CDC's PEPFAR program activities, CDC's Office of the Chief Financial Officer reviewed financial transactions for CDC's other global health programs.

Scope

CMAS II visits were designed to provide an overview of CDC country programs and identify good practices and areas for improvement. While the scope of these visits was primarily focused on CDC/DGHA's activities implemented through PEPFAR, other CDC global health programs were assessed in countries where they have a significant presence. Financial management activities were assessed for all CDC programs in-country. CMAS II visits were not considered comprehensive, nor were they intended to replace Inspector General audits.

Objectives

DGHA conducted a CMAS II visit to South Africa from April 8-12, 2013. The principal objectives of this visit were to:

- Perform a CDC headquarters assessment of internal controls in the field to ensure the highest level of accountability;
- Review intramural and extramural resource management to ensure financial stewardship of U.S. government funds;
- Generate a multidisciplinary snapshot of how CDC country offices are performing regarding programmatic effectiveness in the areas of AIDS-Free Generation Strategy, site visits, and data driven programs to ensure DGHA is achieving the greatest public health impact; and
- Provide clear feedback and technical assistance to the country office to improve current internal controls.

Methodology

CDC headquarters in Atlanta assembled a multidisciplinary team of 11 CDC subject matter experts in the following areas to perform the CMAS II assessment: financial management, program budget and extramural

resources, grants management, country management and operations, and several key technical program areas (e.g., science office, strategic information).

The CMAS II team conducted a five-day visit to the CDC/DGHA office in South Africa (CDC/South Africa). Team members reviewed financial and administrative documents at CDC and grantee offices and conducted administrative and technical grantee site visits, one-on-one meetings with staff, and data quality spot checks. Subject matter experts developed assessment tools and checklists at CDC headquarters in consultation with CDC field staff representatives. A standardized assessment instrument gauged performance using a four-level capability maturation scoring scale. Team members provided additional recommendations for quality improvement and noted good practices observed during the visit that will be shared across DGHA country programs. This methodology provides a "point-in-time" synopsis of CDC/South Africa's operations.

Background on Country Program

South Africa has the greatest number of persons living with HIV/AIDS of any country and has an estimated adult HIV prevalence of 17.3%. In financial terms, South Africa also has the largest PEPFAR program, and CDC has a very large and comprehensive set of programs there. After many years of neglecting HIV, the South African government is now deeply engaged with responding to the epidemic. An enormous transition of services from U.S. government-funded grantees to direct support by the South African government is underway, as was negotiated through the Partnership Framework Implementation Plan.

CDC/South Africa maintains an office with more than 100 total staff, 21 of whom are U.S. direct hires. In addition to the DGHA staff (14 U.S. direct hire, 44 locally employed, 1 contract) carrying out the PEPFAR program in South Africa, the Global Disease Detection Center in the CDC/South Africa office is run by CDC staff from several divisions.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

Major Achievements

The management and leadership review of CDC/South Africa involved 31 one-on-one interviews and an online survey of employee viewpoints with 51 CDC staff members. In addition, the CMAS II team conducted a meeting with the U.S. Embassy Human Resources Officer and reviewed information technology systems, inherently governmental duties, and time and attendance files. The Country Manager also met with the PEPFAR Coordinator, the Chargé d'Affaires, and the U.S. Agency for International Development Health Team Lead.

CDC/South Africa staff expressed a strong understanding of the mission, goals, and objectives of the organization. High levels of respect between staff and senior leadership were evident in the one-on-one interviews. The majority of staff reported that management appreciates their work and demonstrates this

through both formal and informal recognition. Staff reported feeling comfortable speaking up to voice their opinion or asking questions at meetings. CDC and its leadership proved to be well-respected and much appreciated within the U.S. government community in South Africa as well as with relevant components of the South African government and other partners.

Major Challenges

CMAS II team members found that internal communication continues to be a challenge and information does not flow freely across all levels of the organization within the CDC/South Africa office. Staff reported this problem across the organization and indicated a desire to be more directly informed of important strategic events and critical, technical updates through written and verbal communication. Due to lengthy vacancies and heavy workload, inadequate attention was sometimes paid to routine supervisory processes. Staff expressed a desire to interact more frequently with senior leadership and have more regular one-on-one meetings with supervisors as well as routine branch meetings.

CMAS II team members also found that the career development of both locally employed and U.S. direct hire staff is impacted by competing priorities that absorb a great deal of staff time. Staff reported that they do not have adequate access to training opportunities, which has led to a lack of a clear career ladder. Staff also expressed a desire for more clarity around how promotions and developmental opportunities occur.

Recommendations

- Continue to implement the new strategic plan to improve communication flow within the organization.
- Review supervisory processes including scheduling regular one-on-one meetings.
- Consider using all-hands meetings and email as a communication vehicle for consistent communication with staff and for updates about new policies and procedures.
- Increase focus on the use of Work Development and Individual Development Plans as career development tools, with the end goal of moving qualified local staff into more senior positions.

Financial Resource Management

Major Achievements

Through interviews and document reviews, the CMAS II team found that locally employed budget and financial staff members are very knowledgeable of both DOS and CDC/South Africa procedures. They demonstrated commitment to ensuring adequate procedures are in place and followed. The U.S. Embassy Financial Management Officer and General Services Officer expressed that CDC leadership is held responsible for ensuring that all transactions are consistent with applicable policies, authorities, and regulations. However, they also received training on various agency authorities and try to remain abreast of current legislation. They noted that they have a very strong working relationship with CDC/South Africa.

Historically, CDC/South Africa has had the largest budget in the PEPFAR program ($194 million operating budget

in 2012). CMAS II team members found that the CDC/South Africa finance team does a good job of tracking and reporting on their budgetary resources. They maintained separate spreadsheets for the management and operations budget, cooperative agreement funding, and the overall status of Country Operational Plan funding from 2004 to the present. In-country generated budget reports also tracked funds at the common accounting number, object class code, and document level.

At the time of the CMAS II visit, finance staff had direct access to the financial systems of CDC and DOS, allowing them to monitor commitments and obligations on a regular basis and produce monthly budget reports for the CDC/South Africa Country Director and Deputy Director. Through the use of a SharePoint intranet website developed in-country, the CDC/South Africa office was able to easily track the funding of their Country Operational Plan activities. With direct access to the Payment Management System, the finance team was able to actively monitor the funding levels and balances for the cooperative agreement grantees. A pipeline report is produced monthly and provided to the U.S. Ambassador and PEPFAR inter-agency team.

Inventory was performed on a quarterly basis. The office did a good job of tracking their assets and maintaining an inventory that is appropriate for an office their size. In the area of procurement and inventory, the CMAS II team noted that in some instances there was not an adequate separation of duties among staff. Staff in the information technology office submitted a procurement request and also received and accepted the item from delivery. The Deputy Director acknowledged that this was problematic and identified staff that would be solely responsible for receiving procured items.

Major Challenges

CDC/South Africa recently moved into a new space and was not able to provide a secure location for its petty cash. As a result, CMAS II team members found that the office did not actively manage its petty cash on site. CDC's Office of the Chief Financial Officer reviewed petty cash transactions for the last two years and noted that all expenditures were appropriate; however, unannounced cash counts were not being performed in accordance with DOS requirements. CDC/South Africa should be commended for having a standard operating procedure for its petty cash; however, a more robust document was necessary. As currently written, it would be difficult for a new person to follow.

The CMAS II assessment also found that the Country Director and Deputy Director only review the status of funds reports for DGHA funding sources. Although cables were issued to the country for Influenza, Global Disease Detection, and other programs, the Country Director and Deputy Director were not routinely monitoring these funds to ensure that obligation rates are reasonable and that fund balances do not appear to be excessive or in danger of being over-obligated. In addition, while financial staff ensure that documents are included on a program's spending plan and require adjustments when necessary, a review of the status of funds spreadsheets revealed that commitments are not deducted from the funds available balance. This presents a risk of overspending funds.

As part of the PEPFAR transition plan, U.S. government funding levels to South Africa will gradually decrease over the next few years. It will be important for CDC/South Africa to continue monitoring their grantees' funding

levels and expenditures as well as the office's management and operations budget.

Recommendations

- If CDC/South Africa reinstates a petty cash fund, the Country Deputy Director or designee should conduct unannounced petty cash counts at least monthly. Occasional Money Holders must also be established and documented.
- Rewrite the petty cash standard operating procedure to provide step-by-step instructions on each stage of the process.
- The Country Director and/or Deputy Director should review and monitor the status of funds for each program receiving a funding cable. Commitments should also be captured in the status of funds reports to reduce the risk of over-obligation of funds.
- Budget reports and financial information reside in different spreadsheets. Recommend consolidating as much as possible and linking the data. Budget reports should also track projections, commitments and obligations separately. The budget reports currently combine all three statuses under one column.

Accountability for Extramural Resources

Grantee Management

Major Achievements

CDC/South Africa had adequate staff dedicated to the management of cooperative agreements. Personnel were dedicated to management activities that have significant cost impacts for the program. Overall, CDC/South Africa's cooperative agreement management appeared to be excellent, with dramatic improvements made within the last two years.

Cooperative agreement management standard operating procedures were well-defined and implemented for office roles and responsibilities as well as for processing standard actions. CDC/South Africa also exhibited robust tracking systems, which continue to be models for other CDC field offices that assist with the full circle of cooperative agreement management.

Following CMAS I, CDC/South Africa implemented an Associate Director for Science restrictions tracking system and actively tried to resolve remaining restrictions. Improved tracking and management of cooperative agreements funded by CDC/South Africa positively impacted the relationship with grantees. CMAS II team members found that the Deputy Director and Project Officers have completed all required trainings.

Grantees noted that relations between CDC/South Africa staff and CDC's Procurement and Grants Office have greatly improved. Technical and administrative support was adequate and provided as needed. Grantee visits adhered to the schedule and occurred on a regular basis.

At the time of the CMAS II assessment, CDC/South Africa maintained six active task orders. The contract files were largely complete, and the required documentation was located easily. Acceptance and approval of invoices

was done in-country. No formal tracking system was in place given the small number of contracts, and the Contracting Officer's Representatives had access to the contract acquisition management system, which tracked all task orders.

Major Challenges

CDC/South Africa had a large cooperative agreement portfolio and a robust system for managing them. However, proper oversight will be needed to maintain and sustain these systems to assure they are used correctly and consistently. Also, CDC/South Africa should ensure that standard operating procedures are thorough and complete. For example, the office ought to have a document tagging standard operating procedure to use for the cooperative agreement library. There was evidence of delays with delegating Project Officers to cooperative agreements due to vacancies and high attrition rates in the office. Also, site-visit reports were not being sent to CDC's Procurement and Grants Office.

Grantees and staff noted that the value-added tax reporting requirements, delays in lifting restrictions, inconsistencies, and confusion with Notice of Award terms and conditions were all issues that can be improved between CDC/South Africa and its grantees.

CMAS II team members found that clear roles and responsibilities are not defined between the in-country Contract Specialist and the Contracting Officer's Representative. Contract deliverables and feedback were currently with the Contracting Officer's Representative and not included in the official in-country contract file. Contract management processes (e.g. procurement initiation process) were known but not documented in a standard operating procedure.

Recommendations

- Create a standard operating procedure for document tagging in the cooperative agreement library on SharePoint.
- Appoint Project Officers for all cooperative agreements.
- Submit site-visit reports to CDC's Procurement and Grants Office's Grants Management Specialist for inclusion in the official grantee file.
- Focus on sustainability and plans for succession regarding oversight, implementation, and maintenance of standard operating procedures.
- Ensure CDC/South Africa receives feedback on reporting requirements.
- Maintain support to grantees regarding administrative processes and changes from CDC headquarters.
- Follow-up with CDC's Procurement and Grants Office on Notice of Award terms and conditions and CDC headquarters for restriction and value-added tax issues.

Grantee Compliance

Major Achievements

All six of the grantees interviewed demonstrated an understanding of requirements in eight key financial areas: audits, cash advances, facilities, direct costs, procurement practices, property, timekeeping, and travel. Additionally, most of the grantees interviewed have adequate policies and procedures in place that further demonstrated their understanding of compliance with requirements in each area discussed.

Major Challenges

The CMAS II team noted no major challenges. However, several of the grantees interviewed relied on manual processes for management of inventory, timekeeping, and other key undertakings. Even though processes were manual, they posed no real threat to the management of the cooperative agreement or stewardship of U.S. government funds.

Recommendations

- Recommend all grantees, the CDC Program Office, and CDC's Procurement and Grants Office continue to collaborate together to ensure grantees have adequate access to technical assistance.

Accountability for Public Health Impact

Major Achievements

CMAS II team members found that the CDC/South Africa team overall has made sound PEPFAR investment decisions, and the resulting program implementation was aligned well with the AIDS-free generation strategy. Consequently, it was clear that PEPFAR South Africa, as a whole, was on track to achieve the World AIDS Day goals for antiretroviral treatment (2.25 million people living with HIV/AIDS on treatment) and prevention of mother-to-child transmission of HIV (269,000 pregnant women receiving antiretroviral treatment) in 2013. While uptake of voluntary medical male circumcision had been lower than planned, the CDC/South Africa team had a corrective plan in place and monitored grantees' progress monthly. These results represented major achievements and improved control of the largest HIV epidemic on the African continent.

Further, the CMAS II team noted excellent progress toward country ownership. The U.S. government successfully negotiated a detailed Partnership Framework Implementation Plan with the South African government. This plan exhibited a declining financial trajectory for the U.S. government; 67% of CDC/South Africa's PEPFAR funding directed to indigenous partners; capacity building aligned with National Department of Health priorities; and a strong Field Epidemiology Training Program that aims to become integrated into the South African National Public Health Institute.

South Africa's MOH and CDC-funded local non-governmental organizations reported uniformly that CDC/South Africa staff members provide substantial and effective technical input in HIV program design, tools, work plans, and project implementation. The National Department of Health and the National Health Laboratory Service praised CDC/South Africa leadership, planning, technical support, and communication at strategic and

operational levels. These critical Ministry grantees observed that over the past three years, CDC/South Africa significantly improved effectiveness over their previously strong efforts. CDC/South Africa's recent emphasis on site monitoring offered an opportunity for technical staff to provide more in-depth technical support to grantees and facility-level providers.

At the time of the CMAS II assessment, CDC/South Africa had dedicated staff with administrative support to fulfill Science Office functions and standard processes in place for protocol, abstract, and manuscript clearance as well as human subjects review. CDC/South Africa also tracked all documents submitted for clearance electronically in real time. All required staff completed their Scientific Ethics Verification training and obtained Scientific Ethics Verification numbers.

Major Challenges

No national antiretroviral treatment Technical Working Group existed to review performance of the HIV care and treatment program. CDC/South Africa also did not currently participate in joint national reviews of HIV program results and had not routinely modified program design based on evaluations conducted by CDC/South Africa or the grantees. Likewise, expenditure analysis was completed, but at the time of the CMAS II assessment, CDC was not using data to inform program planning or partner budgets of targets.

Operational plans at the district level and monitoring systems for program transition were under development. With the current focus on improving data quality in direct health information systems, non-governmental clinical grantees followed national district health management information systems policy and no longer relied on stand-alone health management information systems for PEPFAR reporting. Submissions of reports containing annual and semiannual results were not always been on time. Recent staff turnover delayed implementation of Site Monitoring System.

Recommendations

- Discuss the feasibility of initiating a national antiretroviral treatment Technical Working Group, and/or incorporating antiretroviral treatment emphasis into existing HIV Technical Working Groups with South Africa's National Department of Health.
- Develop system to monitor impact of evaluations on policy, guidelines, program design and/or implementation.
- Finalize and implement technical assistance indicators to monitor transition process and program monitoring framework to monitor transition outcomes.
- CDC program and strategic information staff should participate in national "Nerve Center" meetings to review district health information system data related to World AIDS Day results at least monthly.
- Develop and consistently implement a written CDC data quality assurance and assessment strategy, which requires grantees to conduct an annual assessment of key reported World AIDS Day indicators.
- Hire technical expert to support a PEPFAR module of the district health information system.
- Identify technical lead for site monitoring. Revise Site Monitoring System strategy to include all sites and grantees.

- Remedy strategic information staffing deficits and submit annual reports and data on time.

Center for Global Health

CDC's Center for Global Health also joined the CMAS II visit. The Center for Global Health provides leadership and implementation guidance for several cross-cutting CDC program and policy initiatives, and it participated in the CMAS II visit to: assess the level to which all CDC programs are integrated in-country; obtain information on Center for Global Health-managed initiatives to contribute to transparency, accountability, and adherence to U.S. Department of Health and Human Services and Department of State regulations; acquire information on policy initiatives or best practices affecting the country office; and work with CDC and U.S. Embassy staff to provide technical assistance and guidance on operations and financial management.

Please note the following section pertains to all CDC/South Africa in-country programs; however, the previous sections primarily focused on DGHA programming only.

Major Achievements

One of the major accomplishments during the CMAS II visit was arranging for the Assistant Regional Security Officer to start the collocation notification process for CDC staff working in MOH space. The Assistant Regional Security Officer conducted site surveys of the National Department of Health and the National Institute of Communicable Diseases facilities on April 11, 2013. Both facilities had adequate security and will require installation of shatter resistant material on the windows. The Center for Global Health will continue to follow up with CDC/South Africa and the Assistant Regional Security Officer on these collocation notifications. The Center for Global Health leadership focused on ensuring all country offices with staff working in facilities outside of the U.S. Embassy complete the necessary documentation. By the conclusion of the CMAS II visit, CDC/South Africa had completed the preliminary steps and had an in-depth of understanding of anything necessary to complete the process.

Major Challenges

The integration of smaller programs into the CDC/South Africa program was challenging given the vast difference in program staff ratios and the differences in organizational structure of the existing programs. Although the non-DGHA programs were much smaller in number, their logistical needs were proportionally higher, specifically in the case of the South Africa motor pool. Most of the Division of Global Disease Detection staff worked part-time either at the National Department of Health or the National Institute of Communicable Diseases, located in Johannesburg 45 minutes away from the CDC office. DGHA staff also visited these facilities on occasion and conducted site visits throughout the area. Additionally, CDC/South Africa continued to receive a larger number of visiting staff from CDC headquarters putting further strains on the motor pool.

Recommendations

- Limit motor pool travel to Johannesburg to scheduled times. Have one car depart/return at 08:00, 12:00 and 15:00 (or other reasonable time). All other travel must be by privately owned vehicle or taxi. Monitor for a few weeks to see if this resolves some of the strains on the motor pool. Another option is

exploring the use of the train, although transport from the train stop to the National Institute of Communicable Diseases seemed difficult and would have to be explored. Staff on temporary duty assignments should stay at hotels near the office or use taxis.

- Track and analyze motor vehicle usage on a regular basis (monthly or quarterly) to uncover inefficiencies. The size of the motor pool should be evaluated against post needs and costs at least annually.
- Consider consolidating the motor pool with the U.S. Embassy and buy-in to the motor pool cost center through ICASS. The motor pool will be consolidated when the CDC/South Africa office moves into a diplomatic space, and many of the management issues around motor pool usage will be alleviated at that time. This may require more coordination and longer lead times for obtaining vehicles. Staff may need to plan their trips in advance and may have to seek alternate transportation.

Next Steps

The CMAS II team shared their key findings and recommendations with the CDC/South Africa office and CDC headquarters. The team also developed a scorecard for internal management use. The scorecard lists all of the issues identified during the visit, recommendations and due dates for their implementation, and primary point of contact for each issue. CDC headquarters will work with the CDC country office to create a plan and timeline to address and correct issues.